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Conscientious objection: a morally insupportable misuse of authority

Abstract

In this paper I claim that the conscience clause around abortion provision in England, Scotland, and Wales is inadequate for two reasons. First, the patient and doctor are differently situated with respect to social power. Doctors occupy a position of significant moral and epistemic authority with respect to their patients, who are vulnerable and relatively disempowered. Doctors are rightly required to disclose their conscientious objection, but given the positioning of the patient and doctor, the act of doing so exploits the authority of the medical establishment in asserting the legitimacy of a particular moral view. Second, the conscientious objector plays an unusual and self-defeating moral role. Since she must immediately refer the patient on to another doctor who is not conscientiously objecting, the doctor is complicit, via her necessary causal role, in the performance of the procedure. This means that doctors are not able to prevent abortions, but rather are required to ensure that they are carried out, albeit by others. Since dropping the disclosure and referral requirements would mean patients might not be able to accept legal medical care, we should instead drop the conscience clause, and encourage those opposed to abortion to select other specialities or professions. This would protect patients from judgement and doctors from complicity.

Introduction

Abortion up to twenty-four weeks has been legal in England, Wales, and Scotland since the 1967 Abortion Act,¹ which also enshrines the right of service providers to conscientiously object to participation in abortion provision. The right to conscientiously object to the provision of certain medical treatments (currently limited to fertility treatments involving embryos and termination of pregnancy) is contested. It has been argued² that since working as a medical professional involves providing medical care in accordance with the law, conscience-based refusals are incompatible with professional responsibilities. This is known as the “incompatibility thesis.”ⁱ Others have defended the conscience clause on the grounds that protecting people’s moral integrity is an important value in itself.³⁻⁴

The General Medical Council (GMC)⁵ outlines the requirements of the conscience clause in terms of good medical practice. Doctors wishing to conscientiously object

i Abortion law in the UK is “permissive” rather than prescriptive, that is, doctors are not *required* to perform abortions but are rather permitted to do so under certain conditions. Strictly speaking, refusing to perform an abortion is therefore not inconsistent with the duties of a doctor.

(CO) to abortion provision are required to do so in accordance with guidelines which recommend that a conscientiously-objecting doctor (hereafter: COD) operating in terms of optimal best practice will implement her conscience clause in the following way:

- (a) Advertise her CO status.
- (b) Tell the patient that she will not perform, or refer for, abortions.
- (c) Tell the patient that she is entitled to speak to a non-COD.
- (d) Ensure the patient has the information of a known non-COD, or hand over the patient to a non-COD without delay.

Were doctors to attend to the requirement in (a), and clearly indicate their intention to conscientiously object to patients and colleagues prior to any consultation, in such a way as to avoid consultations with patients requesting abortions, the successive guidelines would be somewhat moot. As it is, pragmatic barriers prevent this from being the case. Patients invariably initially see whichever doctor is available at the time of need, doctors regularly move between placements at different hospitals and clinics, and there are no extant fora for promoting one's moral views in advance of consultation.

These requirements constitute what Brock⁶ calls the “conventional compromise” for conscientious objection, which states that doctors may conscientiously object provided they adequately inform the patient of other services, refer the patient on to those services, and that this does not place an unreasonable burden upon the patient.

In this paper I wish to explore two facets of the requirements on CODs. The first is the “disclosure” requirement, summarised in (a) and (b); the second is the “referral” requirement, summarised in (c) and (d). I show that these two aspects of the conscience clause render it both morally problematic and ultimately ineffective. I do so by exploring the social meaning of medicine and medical professionals within the broader epistemic community in which they work, as a way of demonstrating that doctors’ speech acts must carry a level of responsibility which reflects the authority they bear. I also explore the meaning of conscience and specifically its relation to complicity, in order to assess whether the conscience clause achieves its own ends of protecting doctors’ moral integrity.

In section one, I argue that the disclosure requirement is a misuse of the social role of doctors as authoritative epistemic agents, and, in section two, that the referral requirement undermines the purpose of the conscience clause by making the COD complicit in the delivery of the abortion. I will attempt to answer two questions: (a)

what effect does the disclosure requirement have on the patient? (b) what effect does the referral requirement have on the doctor?

I will demonstrate that these requirements undermine the objective of the conscience clause, which is to offer doctors the option of saving their consciences without negatively impacting on patient care. I will argue that:

- a) the disclosure requirement involves a misuse of the power and authority of doctors which negatively impacts patient care;
- b) the referral requirement renders doctors complicit in abortions, and therefore does not save their consciences;
- c) any attempt to remove or weaken either the disclosure or referral requirement makes the compromise even more compromising to both parties.

1. Misusing authority: the disclosure requirement

Doctors and patients are not equally-positioned within a consultation, but occupy poles of a power dynamic as a result of their roles within the interaction. There are a multiple causes of this power disparity. First, patients are disempowered due to the

vulnerabilities arising from ill-health, and medical professionals are empowered by their (assumed or actual) capacity to relieve pain or discomfort. Further, as a rule, patients are not scientifically literate, while medical professionals are known to have undertaken extended, rigorous training pathways in elite institutions.ⁱⁱ This produces a mystique which is connected with medical personnel, apparatus, environments, and nomenclature, all of which concentrate in a highly-ritualised context, in which the ease and convenience of the consultation or treatment might be jeopardised were the patient to openly oppose the doctor's authority. Patients are therefore understandably more likely to trust and comply with their doctors' recommendations rather than interrogate or resist.⁷

Further, medicine itself evokes a strong moral legitimacy. It is widely believed that the medical enterprise is motivated by morality, and that those within it share this moral legitimacy. Of course, medicine arises from need, and even socialised medical systems are economically justified.ⁱⁱⁱ Further, doctors benefit from attractive remuneration packages, and medical professionals have better job security than

ⁱⁱ By this I mean universities, which remain inaccessible to so many in the UK context.

ⁱⁱⁱ Medicine may be seen as a biopolitical lever: it perpetuates and ensures the productivity of a healthy population of potential workers and soldiers, in order to produce and protect state capital. In other words, the cost of state healthcare offsets the economic cost of lost labour through poor health.

many other employment sectors—moral motivations may not be most determinative for those who choose these vocations. This notwithstanding, there is a widespread belief that medical professionals are “good” people, and this impression is likely to flavour patients’ responses to doctors’ moral judgements.

It is also important to consider the social context of abortion. Abortion is still associated with considerable stigma. Although it is socially acceptable to defend (even publicly) the right to abortion services, *having* an abortion is a different matter. Discussing one’s own abortion, or requesting it, remains challenging and uncomfortable, and women who do so may experience stigma.⁸ It is one thing to endorse philosophical arguments; it is another to personally undergo a procedure which others equate to murder, even if one vehemently disagrees with them. The presence of anti-abortion protesters outside abortion clinics exacerbates this.

1.1 A “best practice” disclosure?

A “best practice” disclosure must presumably leave the patient clear that abortions are legal in England, Scotland and Wales, subject to certain conditions. Not all patients will be positioned to fully understand what is meant by conscientious objection, and may interpret the unexpected complication as a more general barrier

to abortion. Revealing the moral nature of the impediment reassures them that the reason for complication or delay is limited to the particular doctor they have seen, and not indicative of other complications and delays. Therefore making a distinction between legal/professional guidelines and personal views is vital. A best practice disclosure might therefore sound like this: “I will not provide a signature because I have moral reservations about abortion, but it is perfectly legal, and I will now assist you in ensuring that another doctor helps you to access the treatment.”

Yet in disclosing a moral reservation, the doctor runs the risk of producing moral distress in the patient. The disclosure of a moral reservation by a powerful and respected person to a vulnerable person, against the backdrop of a society in which abortion is still stigmatised, seems deeply problematic. When a person with positional epistemic and moral credibility endorses a moral position within that context, they are likely to bring about shame, guilt, discomfort, and in some cases, deterrence. Given that conscientious objection is supposed to not place burdens upon the patient, this disclosure seems to violate that aim. Though in well-managed cases there may be no practical burden, there is clearly considerable risk of an emotional/moral burden. This combination of epistemic authority and moral authority (if the two can even be separated) is dangerous in relation to abortion, since patients are likely to approach doctors in states of distress and uncertainty.

Savalescu, a vocal opponent of conscience clauses in medicine, recommends that abortion consultations be managed in accordance with “rational non-interventional paternalism”⁹⁻¹⁰ according to which doctors engage in non-directive moral dialogue with patients, permitting the patient to make the eventual decision. Yet this is clearly not appropriate for this setting for the reasons just mentioned. Specifically, it neglects to consider the power dynamic of patient and doctor, and the broader social meanings of particular medical treatments.

1.2 A *better* “best practice” disclosure?

In order to prevent the misuse of doctors' authority, one could uphold the right to CO, but require that doctors do not reveal any moral judgement. What might an improved best practice disclosure consist of then? If the moral judgement is the issue, then perhaps one could avoid or disguise the moral component of the disclosure. Consider this “better” best practice disclosure: “That’s not part of my role, but there’s another doctor here who deals with abortions.”

This would remove the possibility of doctors’ conscientious objections causing moral distress to their patients, but raises other problems. First, it would be

dishonest, by implicature — the patient might reasonably infer that only some doctors are permitted to provide signatures/treatment, which would be false. Dishonesty, even in the name of protecting patients, is paternalistic, and if discovered, endangers the extent to which patients can trust their doctors, which is likely to result in a climate in which doctors cannot provide optimal care. Second, and perhaps more importantly, it would eliminate the COD's only opportunity to articulate moral concern, rendering her more *complicit* in any eventual abortion. It would essentially be a silencing of dissent in relation to a matter of great personal importance to that doctor. It is not clear that any COD would agree to such a route when disclosure offers the only opportunity within the current protocol for CODs to express their strongly-held views on abortion, and may be their only opportunity to offset the moral compromise they may feel in contributing to the eventual procedure.

2. Conscience and complicity: the referral requirement

“That’s like saying, ‘I don’t kill people myself but let me tell you about the guy down the street who does.’ What’s that saying? ‘I will not off your husband, but I know a buddy who will?’ It’s the same thing” (Karen Brauer, president of Pharmacists for

Life.)¹¹

In the context of abortion provision in medicine, conscience claims need not be justified, and are not scrutinised for authenticity, rather they are deemed to be constitutive of moral integrity, the preservation of which is an important social value. As West-Oram and Buyx note:¹² the right to CO is thought to be “vital for the adequate toleration of different moral and philosophical perspectives in a pluralistic society.” Failing to act in accordance with one's conscience, or being coerced into violating one's own conscience, may be psychologically troubling or even damaging, and is generally regarded to be better if society can guard against this, especially if there is no cost to others in doing so.

A common argument within this literature ^{2, 3, 13} proceeds as follows: we should permit CO because it is beneficial to medicine for there to be conscientious doctors. There seems to be a scope ambiguity in terms of whose interests the “conscientious” actions are supposed to serve. This argument seems defensible when conscientious action dovetails with the needs of patients and signifies a broader commitment to prioritising the needs of patients across different contexts, even regardless of existing laws/guidelines. It is less obviously defensible when it conflicts with patients' needs in accessing legal treatments. It is not at all clear that we should uphold exercises of

moral integrity whose sole beneficiary (if any) is an individual who has other employment options available, and which will likely inflict harms on multiple vulnerable people with very limited options in terms of healthcare provision.

2.1 A “best practice” referral?

Let us assume that those opposed to abortion believe that abortion is the murder of a foetus, where foetuses are persons, and have as much right to life as other persons. It is not surprising that doctors who hold this view do not want to contribute to, or engage with, the practice of abortion. However, further arguments are required to defend doctors subsequently passing moral distress and practical burdens onto to their patients.

Rosamund Rhodes¹⁴ points out that: “the doctor who chooses to avoid personal psychic distress declares his willingness to impose burdens of time, inconvenience, financial costs, and rebuke on his patients so that he might feel pure. [...] Someone who places his own interests above his patients’ departs from medicine’s standard of altruism and violates a crucial tenet of medical ethics that every physician is duty

bound to observe.” (p. 78).^{iv}

Yet the referral requirement precludes the maintenance of this “pure” moral state! Rather, professional guidance requires that the COD ensures that the patient reaches a non-COD without significant delay. This requirement inserts CODs into the causal chain which ends with an abortion; they necessarily become part of the bureaucracy of abortion provision, even if they are not part of its direct physical implementation. While they do not fall within the final two causal steps of providing the abortion, they must become part of the prior link of the causal chain. Therefore, not only can they not prevent an abortion from going ahead, they are required to ensure that it does happen (provided the patient continues to desire it, and is eligible for it), by helping patients reach non-CODs with no loss of time. CODs are *de facto* abortion facilitators.

As Schuklenk notes “Looked at from a conscientious objector’s perspective, this compromise is anything but a compromise. If I object to abortion because I believe that abortion is akin to murder, as Christian objectors happen to believe, surely my

^{iv} The tenet in question is beneficence, which requires that the patient’s best interests be the driving concern of the doctor. However, one could equally argue that such a doctor would also be violating the principle of non-maleficence by causing distress to the patient, as well as the principle of autonomy, by denying the patient her right to make a reasoned, informed decision about her health.

moral responsibility is barely smaller if I knowingly pass a pregnant woman looking for an abortion on to a colleague who will commit the act rather than if I do it myself.”¹⁵

The “conventional compromise” is therefore not such for those who believe that abortion is equivalent to murder, for they are required to assume complicity in that “murder”. It may qualify as a compromise for mere “yuck factor” objectors (i.e. those who simply find abortion to be mildly discomfiting) but those concerns are surely not sufficiently robust to reduce the quality of patient care; medicine is, after all, a challenging profession.^v

If a person strongly believes that an act is objectionable, where possible they should obviously not engage with that act. They certainly should not pursue an area of employment in which their only options are to be at one, two, or three removes from its instantiation. In the case of doctors, medicine is not a profession that one is obliged to take on out of desperation (compare with the moral distress many prostitutes must face), and within medicine, there are a wide range of sub-specialties, most of which permit the doctor to avoid abortions altogether. It shows low regard

^v Consider that other aspects of standard medical care, such as triage and surgery, may also elicit “yuck factor” responses.

for ones' conscience to place it second to a preferred choice of sub-specialty. If a person does decide to relegate and devalue her conscience in this way, why should others then make allowances for the protection of that conscience?

Before closing this section, I wish to address a potential objection to this line of reasoning. While CODs are required to provide information about non-CODs, professional guidance does not require them to directly refer the patient to those doctors. This might be seen to undermine my claim that conscientiously-objecting doctors become part of the *causal chain* which ends with abortion.^{vi} Two things can be said in response. First, I am concerned in this paper not with the “bare minimum” in terms of adherence to professional guidelines, but rather with how doctors might exemplify “best practice” in relation to conscience claims. While professional guidance may not require a direct referral, doctors are supposed to be primarily concerned with delivering patient-centred care, and in that case, since professional guidance demands that one act without delay to the patient, one might argue that direct referral is nonetheless the most professionally appropriate course of action. Second, in a manner of speaking, providing information about CODs is equivalent to making a medical referral, since referrals to specialists within the NHS routinely require patients to make their own appointments with the department in

vi Thanks to a reviewer for identifying this issue.

question, based on information given by their general practitioner.^{vii}

2.2 A *better* “best practice” referral?

Coupling CO with a referral requirement means that doctors are not able to prevent abortions, but rather are required to ensure that they are carried out, albeit by others. As such, the operative moral that the conscience clause protects is not that foetuses should not be aborted, but that a doctor's role in the abortion should be one step further away from the abortion than her non-COD colleague. It is not clear that this is a worthy cause if its motivating value—that foetuses should not be aborted—is entirely unaffected. It is not clear to me that any ethical theory or rational moral agent could easily accommodate such undermining conditions on the practice of morals.

What might a better “best practice” referral look like? It seems as though principled CODs should deliberately train in general practice or obstetrics and gynaecology and

vii In such cases, the referring doctor “permits” the specialist case, rather than just providing information, but this a form of gate-keeping that is not substantively different to the gate-keeping undertaken by giving the information of someone one *knows* to be a non-COD, which is information the patient could not readily access.

then illicitly or openly refuse to refer.^{viii} This would ease their consciences, but it would also deprive patients of care that is routine, and thereby disregard their bodily autonomy, which is an important tenet of medical ethics. It would ultimately end with CODs being struck off, so as a long-term strategy it would be self-defeating.

Since dropping the referral requirement would mean patients would not have reliable access to a standard medical procedure, we should instead drop the conscience clause, and encourage those opposed to abortion to select other specialities or professions.

Conclusion

The conscience clause for CODs working in England, Scotland, and Wales is self-defeating. It promises to balance the health needs of patients against the limits of doctors' consciences, and ultimately serves neither adequately. If it were to be made stronger, so that doctors did not need to facilitate the patient's consultation with a non-COD, their conscience needs would be better met, but patients would be

^{viii} Fiala and Arthur,¹⁶ (pp. 13-14) outline several cases in which medical professionals either refuse to refer, or deliberately delay or withhold legal treatment, thereby over-stepping what the conscience clause permits.

impeded from accessing a legal treatment upon which their right to bodily autonomy depends. If it were to be made weaker, and forbade doctors from articulating their personal views on abortion while ensuring immediate referral to a known non-COD, the health needs of vulnerable patients would be better met, but the complicity of CODs in the delivery of abortion would be prohibitively violating to their consciences.

CODs are ostensibly being permitted to exercise their consciences, but in reality becoming administrators in a system which rightly ensures that women can exercise their free and legal right to an abortion. It is more respectful for legislators (who are evidently and rightly committed to the legality of abortion) to recognise that serious consciences cannot be fobbed off so easily.

CODs should conscientiously object by electing not to enter specialties which may involve being complicit in abortion provision. Then the concerns about both referral and disclosure disappear. Junior CODs might claim it would be unfair to leave them fewer specialties to choose from. But surely it is a point of pride and a powerful enactment of principle to boycott something one believes is deeply wrong, and most importantly of all: it is a great and rare privilege to be able to do so within one's own profession, due to the breadth of available specialties.

The current disclosure requirement means that already vulnerable patients are exposed to the burdens of moral judgement by doctors, exacerbated by the unequal power dynamic which characterises medical consultations; the current referral requirement leaves CODs very proximally complicit in the provision of abortion. We should abolish the conscience clause and protect both groups at once.

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